GLYNN
PHYSICAL THERAPY

PATIENT IDENTIFICATION AREA

Quick DASH
SHOULDER, ELBOW, HAND

Please rate your ability to do the following activities in the last week by circling the number below with the appropriate response.

Activities	No Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	Unable
1. Opening a Tight Jar	1 ❑	2 ❑	3 ❑	4 ❑	5 ❑
2. Do heavy household chores (e.g. wash walls, floors)	1 ❑	2 ❑	3 ❑	4 ❑	5 ❑
3. Carry a shopping bag or briefcase	1 ❑	2 ❑	3 ❑	4 ❑	5 ❑
4. Wash your back	1 ❑	2 ❑	3 ❑	4 ❑	5 ❑
5. Use a knife to cut food	1 ❑	2 ❑	3 ❑	4 ❑	5 ❑
6. Recreational activities in which you take some force or impact through your arm., shoulder or hand (e.g. golf, hammering tennis, etc.	1 ❑	2 ❑	3 ❑	4 ❑	5 ❑
	Not At All	**Slightly**	**Moderately**	**Quite a Bit**	**Extremely**
7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups?	1 ❑	2 ❑	3 ❑	4 ❑	5 ❑
	Not Limited At All	**Slightly Limited**	**Moderately Limited**	**Very Limited**	**Unable**
8. During the past week, were you limit-ed in your work or other regular daily activites as a result of your arm, shouler or hand problem?	1 ❑	2 ❑	3 ❑	4 ❑	5 ❑
Please rate the severity of the follow-ing symptoms in the last week (Circle Number)	**None**	**Mild**	**Moderate**	**Severe**	**Extreme**
9. Arm, shoulder or hand pain	1 ❑	2 ❑	3 ❑	4 ❑	5 ❑
10. Tingling (pins & needles) in your arm, shoulder or hand	1 ❑	2 ❑	3 ❑	4 ❑	5 ❑
	No Difficulty	**Mild Diffculty**	**Moderate Difficulty**	**Severe Difficulty**	**I Can't Sleep**
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand *(Circle Number)*	1 ❑	2 ❑	3 ❑	4 ❑	5 ❑
Column Total					

Therapist Name: ______________________________

Date: ________________ **I/E** **F/U** **D/C**

Score:___________

Disability / Symptoms Score = $\left(\left[\frac{\text{Sum of n responses}}{n}\right]-1\right) \times 25$

Where n is equal to the number of completed responses.

"Note" A Quick DASH Score may not be calculated if there is greater than 1 missing item

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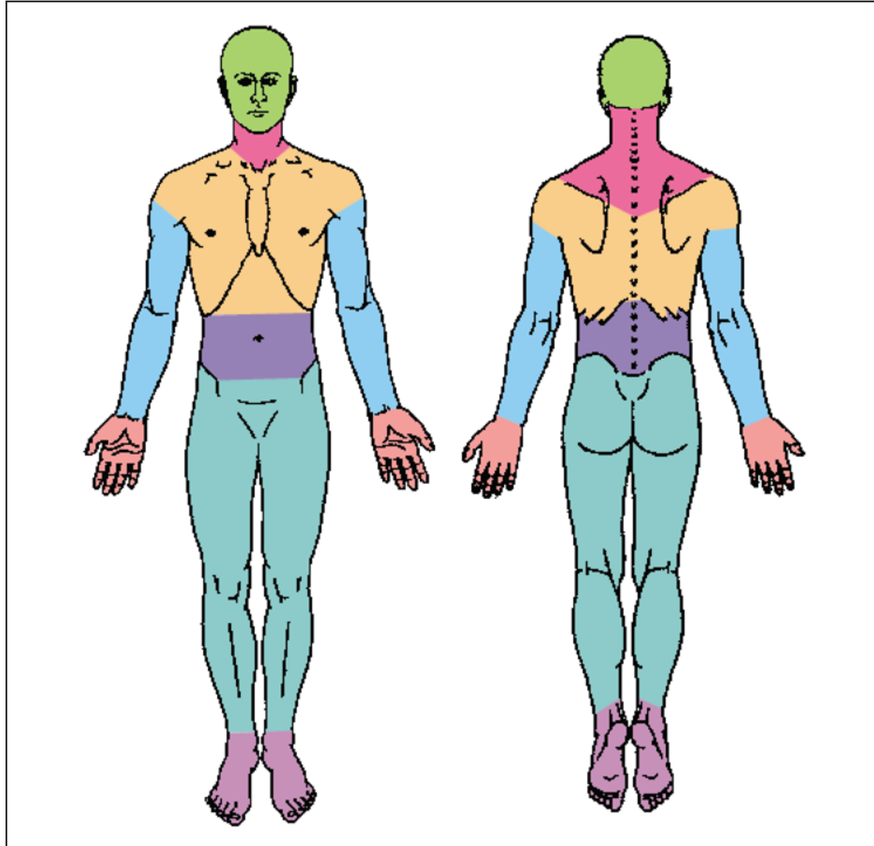
PAIN DIAGRAM AND RATING

Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours.
You may also fill this part out at the time of your visit.

Key:	Pins and Needles = 00000	Stabbing = ////////
	Burning = xxxxx	Deep Ache = zzzzzz



Please rate your *current* level of pain on the following scale (check one)

0❑ 1❑ 2❑ 3❑ 4❑ 5❑ 6❑ 7❑ 8❑ 9❑ 10❑
(no pain) (worst imaginable pain)

Please rate your *worst* level of pain int the last 24 hours on the following scale (check one)

0❑ 1❑ 2❑ 3❑ 4❑ 5❑ 6❑ 7❑ 8❑ 9❑ 10❑
(no pain) (worst imaginable pain)

Please rate your *best* level of pain in the last 24 hours on the following scale (check one)

0❑ 1❑ 2❑ 3❑ 4❑ 5❑ 6❑ 7❑ 8❑ 9❑ 10❑
(no pain) (worst imaginable pain)

Therapist Name:________________________________

Date: __________________ I/E F/U D/C